C-38-1 (11/05)

Department of Labor & Economic Growth
Office of Human Resources
P.O. Box 30004
Lansing, Michigan 48909

MEDICAL CERTIFICATION BY PHYSICIAN OR PRACTITIONER - EMPLOYEE

Complete this form if leave is for you. Complete C-38-2 form if leave is for care of a family member.

Section I – To Be Completed By Employee – Identification Information

Employee's Name	Employee I.D. Number	Classification	Bureau/Office/Commission or Division

Home Address (Street, Apt. No.)	City	State	ZIP Code

Home Phone Number	Work Phone Number	Bargaining Unit	TKU
( ) -	( ) -		

Authorization to Release Medical Information*

I authorize the attending physician or practitioner to release the information requested to my employer regarding my physical or mental condition (as to how it will affect my work activity). By signing this release, I understand that I am agreeing that my employer may obtain and use such necessary medical information provided below about me including information relative to HIV or AIDS, if applicable. This information will only be obtained and used as necessary to process this request for leave of absence. **Note: This information is retained on a confidential basis by the Department in accordance with applicable Civil Service Commission rules and/or collective bargaining agreements and consistent with applicable federal and state law.**

Employee Signature _____ Date _____

Section II – To Be Completed by Physician or Practitioner – Certification of Medical Condition of Employee

Patient's Name	First day of Medical Leave	Probable Duration of Condition	Anticipated Return to Work Date

Describe the medical facts which support your certification, and explain why the employee is unable to work.*

Is employee able to perform the functions of employee's position? (Answer after reviewing statement from the employer of the essential functions of the employee's position, or, if none provided, after discussing with employee.)	Is employee able to perform work of any kind?
☐ Yes ☐ No	☐ Yes (give examples) ☐ No (explain above) (attach additional sheets if necessary)

Name of Physician or Practitioner (print)	Type of Practice (Specializations, if any)	Telephone Number
		( ) -

Address	City	State	ZIP Code

Physician or Practitioner Signature _____ Date _____

* Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.